STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING _____ B. WING _____	03/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENNINGS HEALTHCARE CENTER	701 HENRY ST NORTH VERNON, IN47265

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00084545, IN00085078 and IN00086453. Complaint IN00084545 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00085078 - Substantiated. Federal/State deficiencies related to the allegations are cited at F315. Complaint number IN00086453 - Substantiated. No findings related to the allegations. Survey dates: February 28, March 1, 2, 3, and 4, 2011 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Survey team: Penny Marlatt, RN, TC	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Diana Siddell, RN Sharon Whiteman, RN (February 28, March 1, 2, and 3, 2011) Census bed type: SNF/NF: 87 Total: 87 Census payor type: Medicare: 8 Medicaid: 74 Other: 5 Total: 87 Sample: 18 Supplemental sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 3/11/11 by Jennie Bartelt, RN.			

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F0223 SS=D	Based on interview and record review, the facility failed to ensure 1 of 2 residents reviewed for abuse were free from verbal and physical abuse by a staff member in total sample of 18. (Resident #24) Findings include: Resident #24's clinical record was reviewed on 3-1-11 at 1:55 p.m. His diagnoses included, but were not limited to multi-farct (sic) (many small strokes) dementia, weakness, back pain, degenerative joint disease, type 2 diabetes, depression and cellulitis. His most recent Minimum Data Set (MDS) assessment, dated 1-29-11, indicated both long term and short term memory problems with inability to recall 3 words after 5 minutes and an inability to identify the current day of the week, the current month or year. The MDS did not identify any mood or behavioral issues directed at other persons.	F0223	I It is the policy of this facility to comply with regulatory requirements to protect our residents from verbal, mental, sexual, and physical abuse, corporal punishment and involuntary seclusion. Resident #24 suffered no negative outcomes from the incident of 1/5/11. Resident #24 was monitored by Social Services for any untoward reactions and none were noted. CNA #10 was suspended immediately and an investigation was completed and disciplinary actions have been acted upon.-. CNA #7 was counseled and disciplinary action has been acted on. Facility DON/SSD has conducted resident interviews with residents who are alert and oriented and interview able regarding staff interactions and any concerns of abuse related items . Non were noted On 1/7/2011 the SSD re-educated staff on types of abuse and reporting alleged abuse in a timely manor. On 3/18/2011 an all staff meeting was conducted to review the requirements for reporting alleged abuse in a timely manor .The DON or designee will conduct random interviews of 5-10 staff members 2 times/week for 3 months to assess their knowledge of the abuse policy and procedure especially in	04/03/2011

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	The facility administrator provided a copy of a document entitled, "Fax/Incident Report" on 3-3-11 at 4:30 p.m. This document indicated CNA #7 contacted the facility by phone on 1-6-11 at approximately 10:30 a.m. to report an incident which occurred the previous day, 1-5-11 at 6:15 a.m. The report indicated CNA #7 was working with CNA #10 in providing morning care to Resident #24. It indicated Resident #24 became combative and bent back the fingers of CNA #10. It indicated CNA #10 then raised and shook her fist in anger at Resident #24. It indicated Resident #24 indicated, "You're not going to hit me," to which CNA #10 indicated, "I am if you keep bending my fingers back." The report indicated the staff members continued providing care to the resident. It further indicated CNA #10 stated to CNA #7 in the presence of Resident #24, "I don't see how anyone can like him; I hate		regards to reporting abuse in a timely manner. SSD or designee will interview residents during quarterly care conference for any concerns related to staff interactions or abuse. Results of these interviews will be reported to the facility RM/QACommittee by the DON no less than monthly for review and recommendations. 4/3/2011	

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	him." In an interview with CNA #7 on 3-3-11 at 12:30 p.m., she indicated the thought of having to report her friend who might lose her job as a result of the report was why she delayed reporting the incident. She indicated she kept thinking about it and could not sleep that night "because it is my job to protect the residents." She indicated she called and reported the incident the following morning [to the facility.] She indicated she was placed on a coaching plan and inserviced on abuse and reporting. She indicated the other employees were inserviced on the same topics on 1-7-11. The report indicated that upon receiving the report of this abuse, the facility suspended CNA #10 pending investigation and was terminated on 1-7-11. The report indicated CNA #7 was provided 1 on 1 inservice education on			

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	reporting abuse and timeliness of reporting abuse. The report further indicated all staff were inserviced on the same topics on 1-7-11. The report and social services documentation indicated Resident #24 was monitored for any untoward reactions and none were noted. The report indicated the facility notified the Indiana State Department of Health (ISDH) on the same date, 1-6-11, that it received the report of the abuse. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=D	Based on interview and record review, the facility failed to ensure staff reported an allegation of abuse timely for 1 of 2 residents reviewed for abuse in a sample of 18. (Resident #24) Findings include: Resident #24's clinical record was reviewed on 3-1-11 at 1:55 p.m. His diagnoses included, but were not limited to multi-farct (sic) (many small strokes) dementia, weakness, back pain, degenerative joint disease, type 2 diabetes, depression and cellulitis. His most recent Minimum Data Set (MDS) assessment, dated 1-29-11, indicated both long term and short term memory problems with inability to recall 3 words after 5 minutes and an inability to identify the current day of the week, the current month or year. The MDS did not identify any mood or behavioral issues directed at other persons.	F0225	Please accept this official notice of dispute in regards to the attached F225 Tag from our recent annual survey from 2/28/2011 to 3/4/2011.It is the policy of this facility to comply with regulatory requirements to protect our residents from verbal, mental, sexual, and physical abuse, corporal punishment and involuntary seclusion. Resident #24 suffered no negative outcomes from the incident of 1/5/11. Resident #24 was monitored by Social Services for any untoward reactions and none were noted. CNA #10 was suspended immediately and an investigation was completed and disciplinary actions have been acted upon.-. CNA #7 was counseled and disciplinary action has been acted on. Facility DON/SSD has conducted resident interviews with residents who are alert and oriented and interview able regarding staff interactions and any concerns of abuse related items . Non were noted On 1/7/2011 the SSD re-educated staff on types of abuse and reporting alleged abuse in a timely manor. On 3/18/2011 an all staff meeting was conducted to review the requirements for reporting alleged abuse in a timely manor .The DON or designee will conduct random interviews of 5-10 staff members 2 times/week for 3	04/03/2011

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	him." In an interview with CNA #7 on 3-3-11 at 12:30 p.m., she indicated the thought of having to report her friend who might lose her job as a result of the report was why she delayed not reporting the incident . She indicated she kept thinking about it and could not sleep that night "because it is my job to protect the residents." She indicated she called and reported the incident the following morning [to the facility.] She indicated she was placed on a coaching plan and inserviced on abuse and reporting. She indicated the other employees were inserviced on the same topics on 1-7-11. The report indicated that upon receiving the report of this abuse, the facility suspended CNA #10 pending investigation and was terminated on 1-7-11. The report indicated CNA #7 was provided 1 on 1 inservice education on			

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	reporting abuse and timeliness of reporting abuse. The report further indicated all staff were inserviced on the same topics on 1-7-11. The report and social services documentation indicated Resident #24 was monitored for any untoward reactions and none were noted. The report indicated the facility notified the Indiana State Department of Health (ISDH) on the same date, 1-6-11, that it received the report of the abuse. 3.1-28(c)			

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F0226 SS=D	Based on interview and record review, the facility failed to ensure staff followed facility policy for reporting an allegation of abuse timely for 1 of 2 residents reviewed for abuse in a sample of 18. (Resident #24) Findings include: Resident #24's clinical record was reviewed on 3-1-11 at 1:55 p.m. His diagnoses included, but were not limited to multi-farct (sic) (many small strokes) dementia, weakness, back pain, degenerative joint disease, type 2 diabetes, depression and cellulitis. His most recent Minimum Data Set (MDS) assessment, dated 1-29-11, indicated both long term and short term memory problems with inability to recall 3 words after 5 minutes and an inability to identify the current day of the week, the current month or year. The MDS did not identify any mood or behavioral issues directed at other	F0226	Please accept this official notice of dispute in regards to the attached F-226 Tag from our recent annual survey from 2/28/2011 to 3/4/2011. It is the policy of this facility to comply with regulatory requirements to protect our residents from verbal, mental, sexual, and physical abuse, corporal punishment and involuntary seclusion. Resident #24 suffered no negative outcomes from the incident of 1/5/11. Resident #24 was monitiored by Social Services for any untoward reactions and non were noted. CNA #10 was suspended immediately and an investgation was completed and diciplinary actions have been acted upon.-. CNA #7 was counseled and disciplinary action have been acted on. Facility DON/SSD has conducted resident interviews with residents who are alert and oriented and interviewable regarding staff interactions and any concerns of abuse realted items . Non were noted On 1/7/2011 the SSD re-educated staff on types of abuse and reporting alledged abuse in a timley mannor. On 3/18/2011 an all staff meeting was conducted to review the requirements for reporting alledged abuse in a timley mannor .The DON or designee	04/03/2011

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	persons. The facility administrator provided a copy of a document entitled, "Fax/Incident Report" on 3-3-11 at 4:30 p.m. This document indicated CNA #7 contacted the facility by phone on 1-6-11 at approximately 10:30 a.m. to report an incident which occurred the previous day, 1-5-11 at 6:15 a.m. The report indicated CNA #7 was working with CNA #10 in providing morning care to Resident #24. It indicated Resident #24 became combative and bent back the fingers of CNA #10. It indicated CNA #10 then raised and shook her fist in anger at Resident #24. It indicated Resident #24 indicated, "You're not going to hit me," to which CNA #10 indicated, "I am if you keep bending my fingers back." The report indicated the staff members continued providing care to the resident. It further indicated CNA #10 stated to CNA #7 in the presence of Resident #24, "I don't		will conduct random interviews of 5-10 staff members 2 times/week for 3 months to assess their knowledge of the abuse policy and procedure especially in regards to reporting abuse in a timely manner. SSD or designee will interview residents during quarterly care conference for any concerns related to staff interactions or abuse. Results of these interviews will be reported to the facility RM/QACommittee by the DON no less than monthly for review and recommendations. 4/3/2011	

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	see how anyone can like him; I hate him." In an interview with CNA #7 on 3-3-11 at 12:30 p.m., she indicated the thought of having to report her friend who might lose her job as a result of the report was why she delayed not reporting the incident . She indicated she kept thinking about it and could not sleep that night "because it is my job to protect the residents." She indicated she called and reported the incident the following morning [to the facility.] She indicated she was placed on a coaching plan and inserviced on abuse and reporting. She indicated the other employees were inserviced on the same topics on 1-7-11. The report indicated that upon receiving the report of this abuse, the facility suspended Staff #10 pending investigation and was terminated on 1-7-11. The report indicated Staff #7 was provided 1			

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	on 1 inservice education on reporting abuse and timeliness of reporting abuse. The report further indicated all staff were inserviced on the same topics on 1-7-11. The report and social services documentation indicated Resident #24 was monitored for any untoward reactions and none were noted. The report indicated the facility notified the Indiana State Department of Health (ISDH) on the same date, 1-6-11, that it received the report of the abuse. 3.1-28(c)			

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F0279 SS=D	Based on record review and interview, the facility failed to plan care to address residents' needs related to moods, eating, pressure ulcers, and falls and failed to ensure care was planned to meet residents' daily care needs identified in residents' assessment. The deficient practice affected 2 of 15 residents in a sample of 18 reviewed for comprehensive care plan development. (Residents #A and #38) Findings include: A policy and procedure for "Documentation" with a revised date of 8/10, was provided by the Administrator on 3/4/11 at 12:45 p.m. The policy indicated, but was not limited to: "Facility nursing staff documents the provision of nursing care according to nursing standards and regulatory requirements. Documentation tools are designed, when completed, to demonstrate the clinical care provided to the resident/patient and to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses. Frequency of nursing documentation is based on resident/patient clinical status, clinical need and regulatory requirements. Components of the nursing documentation process included, but were	F0279	It is the policy of this facility to comply with regulatory requirements regarding the development and implementation of the comprehensive care plan. Resident #A's comprehensive care plan has been revised to include care plans for hygiene/bathing, mood, eating, pressure ulcers, and falls. Resident #38's comprehensive care plan has been revised to include care plans for communication problems, ADLs (including bathing/hygiene, toileting, and transferring) A comprehensive QA of each resident's care plans is being conducted to identify care plans for moods, falls, pressure ulcers and eating/ADLs. Identified issues will be corrected as the QA is being completed. The IDT has been re eductated on the regulatory requiremnts regarding development and implementation of comprehensive care plans. A comprehensive QA of each resident's care plans is being conducted to identify issues based on the CAA's(care assessment areas) and other nursing assessments. Care plans for deficit areas will be developed and implemented over the next 90 days as quarterly MDS's come up for review. The DON or designee will QA the clinical record of 4-5 new admission, annual and/or SCOC MDS CAA's and other nursing assessment	04/03/2011

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	not limited to, the following...Development and documentation of resident/patient individualized interviews and goals through the care plan process...Admission documentation is initiated upon admission. After the first day of admission, nursing staff continues to work with the interdisciplinary team to further evaluate the resident/patient and assist in developing the comprehensive plan of care. The interdisciplinary team continues to observe and evaluate the resident/patient to complete the first comprehensive care plan...." 1. Resident #A's record was reviewed on 2/28/11 at 2:00 p.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, dementia, debility, cerebral vascular disease, and diabetes mellitus. An admission minimum data set assessment (MDS) dated 4/23/10 indicated Resident #A had moods of withdrawal from activities of interest and reduced social interaction, required limited assistance of one for eating, had no falls, and had no pressure ulcers or healed pressure ulcers. A significant change MDS, dated 2/15/11,		tools each week for 3 months to insure appropriate care plans are being developed and implemented in a timely manner. The results of these QA will be reported by the DON to the facility RM/QA Committee no less than monthly for review and recommendations. 4/3/2011	

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	indicated Resident #A had a total mood score of 7, indicating a high frequency of moods, required limited assistance of one for eating, had a fall within the last two to six months, and indicated the resident was at risk of developing pressure ulcers but did not have an unhealed pressure ulcer. The significant change MDS dated 2/15/11 indicated the following areas should have a care plan to address resident care: mood, eating, pressure ulcers, and falls. The care plan failed to include mood, eating, hygiene/bathing, pressure ulcers and falls as problem/issues with goals and approaches. During an interview on 3/3/11 at 4:24 p.m., the Director of Nursing indicated she found a restorative walking care plan for Resident #A and indicated this resident did not have a care plan for the other areas. During an interview on 3/4/11 at 1:30 p.m., the Director of Nurses indicated the facility uses the state guidelines for care plan development.			

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F0279 SS=D	2. Resident #38's clinical record was reviewed on 3-1-11 at 9:40 a.m. His diagnoses included, but were not limited to, closed head injury as a result of a motor vehicle accident, left hemiparesis, aphasia (inability to speak or talk), depression, mild presenile dementia, dysphagia (difficulty in swallowing), and osteoarthritis. His most recent Minimum Data Set (MDS) assessment, dated 2-4-11, indicated moderately impaired abilities to make decisions regarding day to day activities. The MDS assessment indicated he required extensive assistance of 2 or more persons in transferring from one surface to another, such as from bed to wheelchair. This assessment also indicated Resident #38 required total dependence on another person for dressing, bathing and general hygiene issues. It indicated he required extensive assistance of 2 persons with toileting. It indicated he was able to feed himself with limited assistance of 1 person. The MDS assessment indicated he has no speech ability in which he is rarely or never understood and in which he rarely or never understands what is said. The MDS assessment summary, dated 11-22-10, indicated care plan triggered areas to include communication. Resident #38's	F0279	It is the policy of this facility to comply with regulatory requirements regarding the development and implementation of the comprehensive care plan. Resident #A's comprehensive care plan has been revised to include care plans for hygiene/bathing, mood, eating, pressure ulcers, and falls. Resident #38's comprehensive care plan has been revised to include care plans for communication problems, ADLs (including bathing/hygiene, toileting, and transferring) A comprehensive QA of each resident's care plans is being conducted to identify care plans for moods, falls, pressure ulcers and eating/ADLs. Identified issues will be corrected as the QA is being completed. The IDT has been re eductated on the regulatory requiremnts regarding development and implementation of comprehensive care plans. A comprehensive QA of each resident's care plans is being conducted to identify issues based on the CAA's(care assessment areas) and other nursing assessments. Care plans for deficit areas will be developed and implemented over the next 90 days as quarterly MDS's come up for review. The DON or designee will QA the clinical record of 4-5 new admission, annual and/or SCOC MDS CAA's and other nursing assessment	04/03/2011

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	current plan of care did not include issues regarding his communication problems, his usual activities of daily living, such as bathing, hygiene transferring, or toileting. In interview with the DON on 3-1-11 at 10:20 a.m., she indicated she could not locate any care plans for Resident #38 regarding ADL's (activities of daily living such as hygiene, bathing and toileting), communication or transfers. She provided a copy of a document entitled "Daily Plan of Care" for use by the CNA's (certified nursing assistants) which detailed care for some of the residents on the same hall as Resident #38. Resident #38's "Daily Plan of Care" entry included information regarding his level of urinary and bowel continency, that he was to receive a mechanical soft diet with nectar thick liquids and the need to remain up for 1 hour after meals in a 90 degree position, that he required 1 to 2 persons to assist with ADL's and for any transfers, to remain with him while he is on the toilet, that he has a communication board that he rarely uses and to use the communication book when trying to talk with him. She indicated this document is not a permanent part of the resident's record. 3.1-35(a) 3.1-35(b)(1)		tools each week for 3 months to insure appropriate care plans are being developed and implemented in a timely manner. The results of these QA will be reported by the DON to the facility RM/QA Committee no less than monthly for review and recommendations. 4/3/2011	

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F0315 SS=D	Based on observation, interview, and record review, the facility failed to ensure appropriate supplies were available to provide timely changes of the urinary catheter and drainage bag for a resident with a urinary tract infection whose catheter was not functioning properly. This deficient practice affected 1 of 7 residents reviewed related to urinary catheters in the sample of 18. (Resident #D) Findings include: 1. On 02/28/11 at 11:25 p.m., Resident #D was observed to be awake and to be resting in bed. A urinary drainage bag attached to the side of the resident's bed was observed to be draining dark amber colored urine. Interview of LPN #1 on 02/28/11 at 2:28 p.m. indicated the LPN needed to change a urinary drainage bag on the last shift she worked (on	F0315	It is the policy of this facility to comply with regulatory requirements for maintaining adequate supplies to meet the residents' needs. 1. Resident #D had no negative outcomes associated with this issue. Resident #D's indwelling catheter and drainage bag have been changed according to the physician's order. All future catheter changes will be completed in a timely manner according to the physician's order.2.Residents with indwelling catheters have been assessed for appropriate physician ordered changes of catheters and drainage bag. No negative outcomes were identified. 3. A par level for indwelling cathers by French and balloon size, drainage bags, and insertion kits has been developed. The Central Supply Clerk will restock the catheter supplies weekly to maintain a par level which guarantees an adequate supply to the residents. The par level will be adjusted as residents are admitted or discharged. DON will re-educate licensed staff on facility par level for indwelling catheters and catheter supplies and staff access to central supply 24 hour a day. The DON will monitor the par level weekly for 3 months to ensure adequate supplies are being maintained to meet the residents with indwelling catheters. 4.The results of this	04/03/2011

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	Sunday, 02/27/11) and there were no drainage bags available. The LPN indicated during the month of January Resident #D's catheter was leaking and there was not a catheter of the size needed to change the resident's catheter. LPN #1 indicated the resident's catheter did not get changed until 3 days later. On 02/28/11 at 10:58 p.m. the DON arrived at the facility to look for urinary drainage bags. After searching through supply closets and telephone texting the person in charge of ordering supplies, she determined there were no urinary drainage bags in the building. She received a telephone text message from the supply clerk which indicated, "There were 2 (drainage) bags today & they were used. Truck in tomorrow." The DON indicated staff had told her there were no drainage bags "yesterday" (Sunday) and "I verbally told (Supply Clerk #1) that we needed drainage bags. There were (2) 16		monitoring will be reported to the facility RM/QA Committee by the DON no less than monthly for review and recommendations.5.4/3/2011	

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	French Foley catheters (common size often used catheter) available in the facility supply of catheters." The DON indicated some supplies were kept locked behind the D hall nurse's station and she and Supply Clerk #1 had a key. The DON indicated she and the supply clerk took turns being on call since they both lived near the facility and if staff needed supplies which were not readily available they could call either the DON or the supply clerk and they would come in and unlock the door. Interview of Supply Clerk #1 on 03/02/11 at 11:15 a.m. indicated there was a lack of drainage bags on the night of 02/28/11. Supply Clerk #1 indicated there was 1 drain bag left on Monday and a drainage bag "busted" and someone used the last remaining drain bag on Monday. Supply Clerk #1 indicated the supply truck came on Tuesday and drainage bags were replenished.			

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Review of Resident #D's clinical record on 02/28/11 at 2:40 p.m. indicated the following:

Resident #D had diagnoses which included, but were not limited to, heart failure, Alzheimer type dementia, and cellulitis.

A physician's re-write order for February 2011 indicated an order, dated 12/17/10, for Foley catheter to bedside drainage - may change every month & as needed - cath care every shift and as needed.

An "Admission/Re-Admission Data Collection & Initial Plan of Care," form, dated 12/17/10, indicated the resident was re-admitted to the facility on 12/17/10 with a Foley catheter and open area on buttocks and lower extremities.

A care plan, dated 12/20/10, indicated, "Problems/issues Foley (catheter) (related to) BPH (benign

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	prostatic hypertrophy)...(Foley Catheter) care every shift... (Change) (every) month & (as needed)...." A 5 day admission MDS (Minimum Data Set) assessment, dated 12/23/10, and an MDS, dated 02/04/11, indicated Resident #D was cognitively impaired and was not reliable for interview, the resident required extensive assistance of staff for care, and the resident had an indwelling urinary catheter. A "Care Track Narrative Note," dated 01/10/11 at 3:30 a.m., indicated, "....(Antibiotic/urinary tract infection) continued...." A "Care Track Narrative Note," dated 01/11/11 at 3:15 a.m., indicated, "...(Catheter) care done. (Antibiotic)/(urinary tract infection) (continued). Urine much clearer and (decreased) odor...."			

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	A "Care Track Narrative Note," dated 01/13/11 at 4:30 a.m., indicated, "(Antibiotic/urinary tract infection) (continued...." A "Care Track Narrative Note," dated 01/14/11 (Friday) at 4:00 a.m., indicated, "...(Decreased amount) urine noted to catheter. Urine clear yellow. (Antibiotic/urinary tract infection) (continued)...(Foley catheter) to (bedside drainage). (Continues) on (antibiotic) Bactrim & Macrobid (antibiotics used to treat urinary tract infections)." A "Care Track Narrative Note" entry, dated 01/14/11 (Friday) at 9:30 p.m., indicated...."(Foley catheter) appears to be leaking. Could not find a 16 (Foley catheter size) - will pass on to a.m. shift to see if they can get one to change it." A "Care Track Narrative Note" for 01/14/11 "11-7" shift, indicated, "(Foley catheter) (continued) to			

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	leak. (No) (16 French) (Foley Catheters) in stock to replace. Will (continue) to monitor....(7-3 shift) (Resident #D) up for meals down to (dining room)....Fluids (encouraged) for (urinary tract infection)." A "Care Track Narrative Note" for 01/16/11 (3-11 shift) indicated, "(Resident #D)....(continues on (antibiotic) for (urinary tract infection) and wounds....(Resident #D) (continues) to pull at & play (with) (catheter). (Catheter) care done." A "Care Track Narrative Note"for 01/17/11 at 4:20 p.m. indicated, "(Antibiotic/urinary tract infection) (continues). (Catheter) care done & (catheter) leaking. (Resident #D) constantly pulling @ cath (catheter) & at penis...(7-11 shift) 2:05 p.m. (Foley catheter) leaking (large) (amount) urine around meatus - unable to flush. Cath occluded. Balloon deflated, much difficulty			

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	removing cath. Waited (approximately) 5 - 10 minutes & able to remove (without) resistance....Will re-anchor cath when correct size Foley obtained....." A "Care Track Narrative Note" for 01/17/11 (3-11 shift) indicated, "(Foley catheter) placed by RN on duty...." Interview of the DON on 03/01/11 at 4:22 p.m. indicated she did not remember anyone telling her they needed a 16 French catheter. The DON indicated she phoned the family and was told by the family that Resident #D's catheter had previously been changed around 12/15/1o or 12/16/10 - shortly before the resident was re-admitted to the facility. A policy titled "Catheter Care" was provided by the DON on 03/01/11 at 3:30 p.m. The policy indicated, "Catheter Care - Indwelling			

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	(catheter) - Purpose: To provide safe and proper care of a resident/patient with an indwelling catheter by evaluating elimination status, minimizing risk of bladder infection....Verify physician's order for catheter care and maintenance...Check catheter system and empty drainage bag at least every shift...Monitor for catheter complications that may result from, but are not limited to: Obstruction... bladder spasms...Leakage around catheter...." This federal tag is related to Complaint IN00085078. 3.1-41(a)(2)			

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F0371 SS=F	Based on observation, interview, and record review, the facility failed to ensure salad dressings were discarded accorded to policy; failed to ensure food items were dated when opened; failed to ensure sanitation buckets were utilized; and failed to ensure kitchen equipment was clean. These observations were made during 2 of 2 kitchen observations. These deficient practices have the potential to affect 85 of 87 residents who eat foods prepared in the facility's kitchen. Findings include: During observation tour of the kitchen with the Dietary Manager present on 02/28/11 at 10:55 a.m. the following observations were made during lunch preparation. Lunch was served at 11:15 a.m. 1. No sanitation buckets were prepared. Interview of the Dietary Manager on 02/28/11 at 11:00 a.m.	F0371	It is the policy of this facility to comply with regulatory requirements to store prepare and serve food in a sanitary manor.F-371 Food Procure,Store/Prepare/Serve-Sanitary1. No residents were identified. Facility complied with re-filling buckets of warm water with sanitizing solution during surveyor rounds in dietary. Buckets were available during the morning shift and were not yet refilled prior to lunch.The jar of Italian Dressing, Salsa, Thousand Island Dressing was immediately discarded. The following items were deep cleaned on 2/28/2011:The gas stove, shelf, jars of spices, deep fat fryer, double convection oven, and the top of the dishwasher. 2. No residents were affected. Facility has conducted a review of dietary opened items to ensure proper labeling of items. 3. Dietary employees were re-inserviced on the following topics:SanitationSanitation and Food ProductionCleaning and Sanitizing / Food and DishcartsCleaning and Sanitizing/ Counters and Tabletops.Food LabelingDietary Service Manager/designee will perform documented QA walking tours of the kitchen area daily which will include proper utilization of sanitation buckets and proper labeling of opened food and following cleaning and sanitation	04/03/2011

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	indicated the sanitation buckets were emptied after breakfast. 2. One jar of "Thousand Island" salad dressing was observed to be 1/4 full and to have black spots on the outside of the bottle. The jar of salad dressing was marked 12/04/10 as the day the bottle had been opened. This jar did not have a use by date. 3. One jar of creamy "Italian Dressing" was observed to be 1/4 full. This jar of dressing was not dated when opened. This jar did not have a use by date. 4. One jar of "Salsa" was observed to be 1/4 full. This jar was not dated when opened and did not have a use by date. 5. One jar of "Thousand Island" dressing was observed to be 1/2 full. This jar of dressing was marked 12/13/10 as the day it was opened. This jar did not have a use		schedules for 3 months. 4. Results of QA rounds will be forwarded to RM/QA for further review and recomendations.5. 4/3/2011	

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	155665	A. BUILDING _____ B. WING _____	03/04/2011

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	by date. 6. The Dietary Manager was observed to throw out a 1/4 full jar of mayonnaise and a 1/4 full jar of pickle relish. These jars had not been dated when opened. The Dietary Manager indicated they were used that morning to make salad. 6. The gas cook stove was observed to have a heavy layer of grease over entire stove. The doors of the ovens were sticky to touch. The shelve over the stove which contained numerous jars of spices was covered with grease and dried spices. 7. A deep fat fryer was observed to be covered with a heavy layer of sticky/greasy residue. Interview of the Dietary Manager on 02/28/11 at 11:10 a.m. indicated the deep fat fryer was due to be cleaned "tonight."			

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	8. A double confection oven was covered with a heavy layer of sticky/greasy residue down the side and sticky/greasy residue on the doors. 9. The top of the dish washer machine was covered with greasy residue and crumbs. Dried food residue was observed down in the lower inside edge of the machine. 10. Dietary Aides were observed starting dip-up of lunch. A soiled rag was observed on the steam table counter. No sanitation buckets had been set up. 11. Interview of Dietary Aide #6 on 02/28/11 at 11:15 a.m. indicated she used rags to clean spills which were provided by laundry. No sanitation buckets were set up for lunch. Immediately after Dietary Aide #6 made this comment, the Dietary Manager instructed her to fill a bucket with soapy water and			

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	use for wipe up of spills. A policy titled "Nutrition Services Manual Food Labeling Reference Guide" was provided by the Dietary Manager on 02/28/11 at 12:30 p.m. This policy indicated, "...When food item is opened and not completely used, write the open date on the food container. Write a use by date on the container...Mustard...salad dressings...mayonnaise....Use within 2 months after opening. A policy titled "Sanitation" was provided by the Dietary Manager on 02/28/11 at 12:30 p.m. indicated, "Nutrition services staff prepares food in a manner that conserves nutritive value, enhances flavor, and prevents food borne illness....Clean and sanitize all work surfaces, equipment, and utensils with approved sanitizer after each task....Use cloths or towels for wiping food spills. Do not use the same towels for other purposes.			

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	Keep a bucket full of warm water with sanitizing solution available; change water every two hours or more often as needed....Cleaning and sanitizing counters and tabletops -Counters and tabletops are cleaned before and after food preparation...Clean off debris using a clean cloth soaked in warm detergent water. Wipe spills immediately during preparation. Wipe with a clean cloth soaked in clear, hot water...." 3.1-21(i)(1)			

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F0514 SS=D	Based on record review and interview, the facility failed to maintain residents' clinical record which were complete and accurately documented in that 1 resident failed to have documentation of a Foley catheter change (Resident #57) and 1 resident had incomplete documentation of tracheostomy care. (Resident#23) This affected 2 of 18 residents reviewed for complete and accurate clinical record documentation in a sample of 18. Findings include: A policy and procedure for "Documentation Guidelines" with a revised date of 8/10, was provided by the administrator on 3/4/11 at 12:45 p.m. The policy indicated, but was not limited to: "All entries into the medical record should be legible, dated, timed, and written in ink. All documentation must include the staff member's legible signature and title...Ineffective documentation practices include but are not limited to...Leaving blanks or spaces in the medical record...." 1. Resident #57's record was reviewed on 3/3/2011 at 10:50 a.m. The record indicated Resident #57 was admitted with diagnoses that included, but were not limited to, quadriplegia and chronic anxiety.	F0514	It is the policy of this facility to comply with regulatory requirements regarding maintaining complete and accurate records of the care provided the residents.1. Resident #57's physician has been notified of the alledged lack of clinical documentation regarding the indwelling catheter change. Resident #23's physician has been notified of the alledged lack of clinical documentation regarding trach care for the identified dates. There were no negative outcomes to either residents regarding the lack of documentation.2. All residents with trachs and indwelling catheters were QA for issues related to documentation of care provided. The physician's of these residents were notified of the deficit charting issues. There were no negative outcomes for any resident whose records were reviewed.3. Licened Nurses, QMAs and CNAs were provided inservicing regarding the professional standards for documentation of these areas by the DON and Administrator on March 18, 2011. The DON or designee will complete weekly QA of the TARs for 3 months to ensure compliance to the documentation of trach and indwelling catheter according to professional practice standards. 4.The results of these audits will	04/03/2011

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	A physician's order dated 10/29/10 indicated an order for a Foley catheter to bedside drainage, 20 french (size of catheter) /30 cc (cubic centimeters) bulb, change every month. Documentation on the treatment flow sheets and nurses notes indicated the Foley catheter was changed in November 2010, December 2010, and January 2011, but no documentation was in the record that the Foley catheter had been changed in February 2011. During an interview on 3/3/11 at 3:45 p.m. with LPN #9, indicated LPN #9 had changed the Foley catheter for Resident #57 on 2/25/11. LPN #9 indicated she had changed the Foley catheter "the day after re-writes" because she had helped with re-writes on 2/24/11, and had changed the Foley catheter the next day. LPN #9 indicated she would write a late entry in the resident's record, and that she had gotten a catheter out of central supplies the day she changed the catheter. 2. Resident #23's record was reviewed on 3/3/11 at 9:25 a.m. The record indicated Resident #23 was admitted with diagnoses that included, but were not limited to, major depressive disorder,		be reorted to the facility QA Comittee by the DON no less than monthly for review and recommendations.5. 4/3/2011	

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	stroke with hemorrhage, diabetes mellitus, congestive heart failure, high blood pressure, asthma, diabetic retinopathy, chronic respiratory failure with tracheostomy, and gastrostomy tube. Physician's orders dated 1/19/11 included an order for tracheostomy care every shift. Treatment administration records (TARS) dated 1/2011 indicated the following times no initials were signed that would indicate the tracheostomy care had been done: 1/20 on the 7-3 shift and 1/21, 1/22 on the 3-11 shift. TARS dated 2/2011 indicated the following dates and shifts tracheostomy care was either not initialed as done or the initials had been circled to indicate the treatment was not done: - 2/16 on the 11 - 7 shift - no initials - 2/18 on the 7 - 3 shift and 11 -7 shift- no initials - 2/19 on the 11 -7 shift, initials were circled with no explanation - 2/20 on the 7 -3 shift, initials were circled with no explanation - 2/21, 2/22, and 2/23 on the 7 -3 shift, no initials - 2/24 on the 11 - 7 shift, initials were circled with no explanation - 2/26 on the 7 - 3 shift, no initials and on			

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	the 11 - 7 shift, initials were circled with no explanation - 2/27 on the 7 - 3 shift, no initials and on the 11 - 7 shift, initials were circled with no explanation During an interview on 3/3/11 at 5:00 p.m., the Director of Nursing indicated the blanks on the treatment administration record meant the nurse's didn't sign it, and if the initials were circled it meant it wasn't done or the resident refused it. She said the nurses should write on the back of the TAR the reason the treatment was not done or if the resident refused. 3.1-50(a)(1) 3.1-50(a)(2)			